Colorado Department of Public Health and Environment

HCP SPECIALTY CLINIC VISIT RECORD

Health Care Program for children with Special Needs

Clinic Date: _____

Clinic Location: _____

Clinic Provider: _____ **Clinic Type:** ☐ Neuro ☐ Rehab ☐ Ortho

Child/Youth's Name: _____

DOB: _____ **Age**: _____ **Gender**: _____ **Insurance:**

Parent's **Name:**

Mailing Address: _____ **City**: _____ **Zip**: _____

County: _____ **Phone**: _____

Name of PCP: _____ **Phone**: _____ **Last Visit**: _____

Address: _____ **City:** _____ **Zip:** _____

Medical condition(s): _____

Medication	Maximum Dose mg/kg/day	Frequency/ Doses	Date Started	Date Stopped	Reason discontinued

Immunization Status: ☐ **Up to Date** ☐ **Needed** **Vital Signs: HR:** _____ **RR:** _____ **BP:** _____

Wt_____**% tile --- Ht:**_____**% tile--- Head Circ.** _____ **%tile --- Plotted: Y** ☐ **N** ☐

CONCERNS: _____

ASSESSMENT: _____

PLAN: _____

TEACHING INTERVENTIONS:

Schedule next specialty clinic appointment in _____ ☐ **weeks** ☐ **months**

Schedule next PCP appointment in _____ ☐ **weeks** ☐ **months**

Nurse Signature: _____ **Phone number:** _____